STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	150133	A. BUILDING 00 B. WING	08/08/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KOSCIUSKO COMMUNITY HOSPITAL	2101 E DUBOIS DR WARSAW, IN46580

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S0000	This visit was for investigation of one State hospital complaint. Complaint Number: IN 00083548 Substantiated; deficiencies related and unrelated are cited Date: 8/8/11 Facility Number: 005113 Surveyor: Linda Plummer, R.N. Public Health Nurse Surveyor QA: claughlin 08/16/11	S0000		
S0754	410 IAC 15-1.5-4(f)(5) (f) All inpatient records, except those in subsections (g), shall document and contain, but not be limited to, the following: (5) Evidence of appropriate informed consent for procedures and treatments for which it is required as specified by the informed consent policy developed by the medical staff and governing board, and consistent with federal and state law. Based on policy and procedure review, patient	S0754	Signed Consents for Treatment and	08/22/2011

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	medical record review, and staff interview, the facility failed to ensure that a general consent to admit and treat form was signed by the patient or their representative, for 2 of 5 patients. (N1 and N3) Findings: 1. at 11:30 AM on 8/8/11, review of the policy and procedure "General and Special Consent for Health Care", policy number: 200-34, indicated: a. under "Policy/Procedure", it reads: "The patient or his/her designated representative has the right to be involved in decision-making regarding the plan of care. The contemplated course of care, the patient's role in treatment, the services at discharge and the patient's understanding and agreement is documented in the physician's progress notes and/or evidenced by a signed informed consent document...Each patient, upon registration at KCH, signs a general consent for treatment and a consent for payment..." 2. review of patient medical records during the 8/8/11 survey process indicated: a. pts. N1 and N3 were lacking the general consent for admission and treatment forms in their medical records 3. interview with staff members NA and NB at 1:30 PM on 8/8/11 indicated: a. after checking with the medical records department, it was determined that pts. N1 and N3 were lacking consent for admission and treatment forms in their medical records, as required by facility policy		Admission as well as Financial Consents will be scanned into the Medical record as soon as they are signed instead of sending paper copies with the record. An audit of 30 medical records will be conducted monthly to ensure the required consents for admission and treatment are present in the medical record. The Director of Admissions is responsible for ensuring compliance and oversight of the medical record audit.	

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S0872	410 IAC 15-1.5-5(b)(3)(P) (b) The medical staff shall adopt and enforce bylaws and rules to carry out its responsibilities. These bylaws and rules shall: (3) include, but not be limited to, the following: (P) A requirement that the the final diagnosis be documented along with completion of the medical record within thirty (30) days following discharge. Based on patient medical record review, medical staff rules and regulations review, and staff interview, the medical staff failed to ensure that a discharge summary was provided for 1 of 5 patient records reviewed (pt. N3) for completion of the medical record within 30 days following discharge. Findings: 1. at 12:05 PM on 8/8/11, review of the medical staff rules and regulations dated November 2010, indicated: a. on page 7, in section 11., it reads: "A discharge summary separate from the history and physical shall be written or dictated on all medical records of patients hospitalized for over 48 hours,...for patients with stays less than 48 hours a progress note or discharge note may be utilized, but must include the outcome of the hospitalization, disposition and	S0872	Education was conducted with the physician involved as well as the Director of Health Information Management. A 100% review of medical records will be conducted monthly to ensure that either a Progress Note or a Discharge Summary is present for all short stays (less than 48 hours), including for patients who left against medical advice and a Discharge Summary is present for all admissions with stays greater than 48 hours. The Director of Health Information Management is responsible for ensuring compliance and oversight of the medical record audit.	08/29/2011

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	provisions for follow up care..." 2. review of patient medical records during the 8/8/11 survey indicated: a. pt. N3 was admitted on 11/30/10 and left AMA on 12/2/10 b. the last progress notes for pt. N3 were documented on 12/1/10 at 12:20 PM and 1:30 PM c. the medical record for pt. N3 was lacking a discharge summary or a final progress note that included the outcome of the hospitalization, the patient's disposition, and provisions for follow up care, as required by medical staff rules and regulations 3. interview with staff members NA and NB at 1:30 PM on 8/8/11 indicated there was no discharge summary or final progress note that would meet the requirements of the medical staff rules and regulations			

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S1186	410 IAC 15-1.5-8 (f)(3)(A)(B)(C)(D)(E)(i)(ii)(iii)(iv)(v) (f) The safety management program shall include, but not be limited to, the following: (3) The safety program that includes, but is not limited to, the following: (A) Patient safety. (B) Health care worker safety. (C) Public and visitor safety. (D) Hazardous materials and wastes management in accordance with federal and state rules. (E) A written fire control plan that contains provisions for the following: (i) Prompt reporting of fires. (ii) Extinguishing of fires. (ii) Protection of patients, personnel, and guests. (iv) Evacuation. (v) Cooperation with firefighting authorities.			
	Based on patient medical record review and staff interview, the facility failed to ensure patient safety in regards to safe discharges for 3 of 5 patients. (pts. N1, N3 and N4) Findings: 1. in review of patient medical records, during the survey process of 8/8/11, it was found that: a. pt. N1: A. had a nursing care plan initiated 12/8/10 that indicated the patient was at risk for falls and seizures with appropriate	S1186	Policy 100-07 "Discharge or Transfer of Patient" was revised to require all patients who are discharged to be transported to their vehicle by wheelchair. If the patient refuses, the refusal is to be documented. Policy 300-06 "Patient's Leaving the Hospital Against Medical Advice" was revised to require these patients to be transported to their vehicle by wheelchair. If the patient refuses to go by wheelchair, the refusal is to be documented. If the patient leaves without the nurse's knowledge the nurse must make calls to the contacts listed on the medical record to ensure	08/26/2011

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	safety measures implemented B. was noted on 12/9/10 at 0235 hours that: "Pt. anxious. Ativan given per request. Pt states it won't help anyway, [pt] just wants a cigarette. Said [pt] will just go in the bathroom and smoke if [pt] can't go outside, or just leave...RN, supervisor notified." C. had documentation at 0255 hours on 12/9/10: "pt decided to leave AMA" (against medical advice) D was noted at 0300 hours on 12/9/10 as: "Pt refuses to sign AMA paper. IV site dc'd. Tele dc'd. Pt. called family to come and get [pt]." E. had nursing documentation at 0306 hours on 12/9/10: "Pt left per self. All belongings with pt." F. lacked documentation by staff that the patient was accompanied off the nursing unit by staff b. pt. N3: A. was noted at 0800 on 12/2/10 that the patient stated: "I'm leaving. I'm tired and I want to go home. I am going home with or without [doctor's] discharge". B. had phone calls to the physician office documented as being placed by both facility nursing staff and the patient until a nursing note at 10:30 AM noted: "pt changed to home clothing, all belongings gathered and walked out. Pt left in stable condition."		the patient reached home safely. If the patient's whereabouts cannot be determined, the police will be notified to look for the patient. All activities surrounding the discharge process must be documented. Nursing Staff on the Med/Surg and ICU/PCU units were educated on the revised policies at department meetings. A 100% audit of medical records of patient's who left against medical advice will be conducted monthly to ensure compliance with documentation requirements. The Director of Quality is responsible for ensuring compliance and oversight of the medical record audit.	

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	C. lacked any documentation by nursing staff that the patient was accompanied from the unit by staff to the safety of family c. pt. N4: A. had nursing documentation at 1430 hours: "Patient seen by Dr...pt signed AMA papers. Discharge instructions given." B. lacked any documentation by nursing staff that the patient was accompanied from the unit by staff to the safety of family 2. interview with staff members NA and NB at 12:15 PM on 8/8/11 indicated: a. there is no facility policy related to how patients are to be discharged from the facility b. it is protocol/standard of practice that all patients are escorted to the front door/entrance of the facility by staff at the tine of discharge (this includes patients who sign out AMA) 3. interview with staff member NC at 2:00 PM on 8/8/11 indicated: a. "everyone is escorted to the front door of the facility by wheelchair"--including patients who sign out AMA b. if the patient refuses the wheelchair, they are still accompanied ambulatory by staff to the main exit of the facility			

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	c. after interview with nursing staff who documented AMA status/discharge for patients N1, N3 and N4, it was determined that documentation was lacking related to whether or not these patients were escorted off the nursing unit, or if the patients left without staff knowledge 4. interview with staff members NA, NB and NC at 2:30 PM on 8/8/11 indicated: a. after interview with the nurse who documented AMA status for pt. N1, it was determined that the patient left the nursing unit alone at 3:06 AM (staff entered patient room and found it empty) b. staff knew the patient's ride could not have arrived by that time (3:06 AM) since not enough time had elapsed between the time of the patient's call to their spouse and when the patient exited the nursing unit c. there is no indication security was notified of a patient who left without accompaniment, or that staff followed or searched for the patient to be sure the patient was safe at 3:06 AM.			